Appeal Form

APPEAL RESPONSE
☐ Check box if this is an URGENT request*

Step 1: CLEARLY PRINT AND COMPLETE – ALL FIELDS REQUIRED FOR APPEAL PROCESSING	
Date:	Prescriber First & Last Name:
Member First & Last Name:	Prescriber NPI:
Member Date of Birth:	Prescriber Specialty:
Member Phone Number:	Prescriber Phone Number:
Member Insurance ID Number:	**Prescriber Fax:**

Step 2: SELECT AN APPEAL REQUEST TYPE	
☐ Prior Authorization Denial	☐ Copay Lowering *These requests ARE NOT prioritized as URGENT
☐ Not-Covered	☐ Quantity Limit Increase
☐ Cost Sharing *These requests ARE NOT prioritized as URGENT and REQUIRE a provider submitted FDA Med Watch Form	☐ Other, Please Specify:

Step 3: COMPLETE REQUEST INFORMATION	
Drug/Dosing:	Diagnosis: NOTE: If diagnosis differs from the initial request denial DO NOT SUBMIT AN APPEAL. Please re-submit the request for initial review under the correct diagnosis to Prior Authorization at fax: 855-668-8551
☐ Continuation Therapy ☐ Initial Therapy	
Drugs/ Therapies previously tried/failed for this diagnosis:	

Step 4: APPEAL
Use the space provided below to appeal the initial denial of this request • Refer to the initial request denial letter and address <u>each denial reason</u> within this appeal. • If denied due to formulary alternatives, address <u>each drug listed</u> within the initial request denial. • Use clinical reason(s)/rationale to explain your disagreement with the initial denial of this request. • Provide chart notes, medical studies/journals and/or any other information relevant to this request.

Step 5: SIGN AND FAX TO: APPEAL COORDINATOR AT: 855-673-6507

Prescriber Signature: _____ Date: _____

Appeal Department business hours are M-F 8am-5pm CST, decision turnaround times are adjusted accordingly.

For questions, please call Navitus Customer Care at 1-866-333-2757.